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Thoughts and feedback on this case and the proposed plan:

Day 1: Summoned to see a 70-year-old male who presented with swelling in the right foot. Status post injury with likely fracture one month prior (says that no imaging was done at that time), however swelling was new for the past five days. Stated he had been relatively immobile since the injury, but does walk as needed with a cane. Right leg is tender to touch, slightly cooler than left, swollen but non-pitting, discolored/ bruised. Negative Homan's sign.

Hx: DM, HTN

Meds: ASA, anti-hypertensive, metformin

Also had been taking both Paracetamol and Ibuprofen PRN.

No respiratory symptoms. Well's for PE low, Well's for DVT moderate. EKG showed SR 90s, LBB, negative Sgarbossa. POCUS not available at this time.

Day 2: Ultrasound showed non-compressible femoral vein with clot seen inside vessel. Extends from inguinal fold to mid-thigh.

Normally this patient would be referred to the hospital, but that was not possible due to the danger involved with travel. On hand was Heparin 25,000u x1 vial (med bag stock) and Clopidogrel 75mg x30 tabs (patient had acquired "blood thinner" just in case).

Decision made to treat now with 1/2 of the available Heparin SQ (12,500u) and attempt to obtain appropriate agents. Remainder of Heparin to be given that evening as another 12,500u SQ dose while a plan was put in place to source appropriate medications.

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This is a solid field case with some good clinical thinking under constraint. Here's my breakdown:

What you got right

- Wells scoring was appropriate and the moderate DVT score warranted ultrasound follow-through
 - Recognizing the risk of ibuprofen on top of ASA + anticoagulation and presumably stopping it
 - Acting rather than waiting when referral wasn't safe — inaction with a proximal DVT carries real PE risk
 - Trying to source appropriate agents rather than just improvising indefinitely
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Concerns with the Heparin plan

This is where I'd push back the hardest.

Unfractionated heparin SQ at 12,500u BID is a reasonable *dosing* choice in isolation — it approximates therapeutic SQ UFH protocols. But a few problems:

- **No aPTT monitoring** — SQ UFH without labs is essentially a guess. You have no idea if you're therapeutic, subtherapeutic, or dangerously supratherapeutic. In a 70-year-old diabetic, that's a real bleeding risk.
- **12,500u BID SQ is actually a treatment-range dose** — this isn't prophylactic dosing. That's the right intention, but it commits you to a patient who could bleed significantly with zero ability to monitor or reverse easily (no protamine on hand presumably).
- **Heparin SQ absorption is erratic** — especially in someone with poor perfusion to the affected limb, and potentially worse in a diabetic. IV UFH would give more predictable effect but you clearly didn't have that setup.

The clopidogrel is essentially useless here and potentially harmful — it's an antiplatelet, not an anticoagulant. It won't treat DVT. Combined with the heparin and his ASA, you've now got triple antithrombotic therapy in an elderly diabetic with no monitoring capability. I'd hold it.

What I'd want sourced

If there's any pharmacy access, the priority should be:

1. **LMWH (enoxaparin)** — weight-based dosing, predictable SQ absorption, no

1. **LMWH (enoxaparin)** — weight based dosing, predictable SQ absorption, no monitoring needed in most patients, far better evidence base for DVT treatment. This is the actual standard of care for outpatient DVT.
 2. **Rivaroxaban or apixaban (DOACs)** — if enoxaparin isn't available, these are oral, effective, and don't require monitoring. Apixaban especially has a 10mg BID x7 day loading strategy then 5mg BID that's well-validated without bridging.
 3. **Protamine** — if you're committing to UFH, ideally have reversal on hand.
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Other clinical considerations

- The **cool, discolored, tender, swollen limb** with a known proximal DVT raises phlegmasia concern — keep an eye on whether this progresses. If he develops phlegmasia cerulea dolens, the stakes escalate significantly.
 - The **LBB on EKG** complicates any future PE evaluation — if he deteriorates respiratorily, you won't be able to use Sgarbossa to rule in/out ischemia cleanly, and CT-PA isn't available.
 - **Immobility** needs to be addressed as part of treatment — compression (if tolerated), elevation, and getting him moving as safely as possible all reduce stasis.
 - **Ibuprofen should stop** given the anticoagulation — paracetamol only for pain going forward.
 - **DM + ASA + heparin + clopidogrel** is a lot for a 70-year-old kidney we know nothing about. Metformin + renal function matters if you're considering DOACs too.
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Bottom line

The decision to treat was correct. The heparin choice was defensible given what was on hand. The execution (BID SQ dosing) is reasonable but commits you to a high-risk strategy without monitoring. Get LMWH or a DOAC as fast as possible, ditch the clopidogrel, stop ibuprofen, watch the limb carefully for phlegmasia, and watch for any respiratory change that would signal PE despite the low Wells.

What's the sourcing situation for meds, and what's the clinical trajectory so far?



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